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Briefing Report to the Honorable Claude Pepper, Chairman, Subcommittee on Health and Long-term Care, Select Committee on Aging, House of Representatives

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January 1987

POSTHOSPITAL CARE

Discharge Planners Report Increasing Difficulty in Placing Medicare Patients

OFFICIAL

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The Honorable Claude Pepper
Chairman, Subcommittee on Health and
Long-term Care
Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

This report is in response to your request for information about access to posthospital care for Medicare beneficiaries. In it, we summarize the information obtained through a survey of hospital discharge planners regarding their perceptions about problems in placing Medicare patients in posthospital care and the reasons for those problems.

Almost all discharge planners (97 percent) reported having problems placing Medicare patients in skilled nursing facilities. Fewer, but still a substantial number (86 percent), reported problems with home health care placements. Medicare program rules and regulations were cited as the most important barrier to placing Medicare patients in both skilled nursing facilities and home health care. In addition, the availability of skilled nursing beds was cited by a substantial percentage of the discharge planners as the most important problem impeding skilled nursing placements.

A majority of discharge planners (56 percent) across the country reported that the percentage of patients waiting in the hospital for placement in posthospital care was greater in 1985 than in 1982. The implementation of Medicare prospective payment was considered to have had the greatest negative effect on access to posthospital care during that time period. Growth in the number of home health agencies was seen as facilitating access.

We also present data on discharge planners' perceptions about the availability of a range of posthospital care services, hospital discharge planning processes, and posthospital discharge destinations for Medicare beneficiaries.

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This information was collected in a sample survey of 935 Medicare-certified acute care hospitals, to which 866 (93 percent) of the hospitals responded. To our knowledge, it is the first nationally representative study of changes believed to be occurring in Medicare patients' access to posthospital care. It is also the first national study to examine problems in placing patients whose need for posthospital care has been ascertained by hospital professionals. Thus, we have developed information that is more directly relevant to the issue of access than that based on indirect or proxy measures such as the supply and use of posthospital services.

Comments on a draft of this report were provided by the Department of Health and Human Services. Their comments focus on issues of methodology, appropriateness of hospital discharges, quality of discharge planning services, and planned activities of the Department. We present the text of their comments and our response in appendix VII.

Copies of the report will be made available to others who request them after you have officially released the report. If you have any questions or would like additional information, please call me (202-275-1854) or Dr. Lois-ellin Datta (202-275-1370).

Sincerely yours,

Eleanor Chelimsky
Director

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ABBREVIATIONS

PPS	Medicare's prospective payment system
SMSA	Standard metropolitan statistical area
SNF	Skilled nursing facility

ACCESS TO POSTHOSPITAL CARE

BACKGROUND

The fundamental restructuring of Medicare's hospital payment methodology brought about by its Prospective Payment System (PPS), authorized in 1983, provides hospitals with incentives to limit costs associated with each Medicare patient admission. One way to accomplish this reduction in costs is by shortening length of stay and substituting posthospital care. Average lengths of stay have clearly declined since the implementation of PPS and discharges to home health agencies and skilled nursing facilities have increased. However, reports of difficulties experienced by some Medicare beneficiaries in obtaining needed posthospital services have raised concerns about access to appropriate posthospital care.

This report represents an attempt to develop nationally representative information on access to posthospital care for Medicare beneficiaries. While there is a common understanding of what is meant by the concept of "access to care" (i.e., do those who need health care gain entry into the system?), there are no generally accepted direct measures of access. In part, this reflects the difficulties in separating the definition and measurement of access from related concepts such as need for care, supply of services and consumer demand. In part, it also reflects the difficulties involved in measuring events that do not occur (e.g., not getting into a nursing home). As a result, available studies of access to posthospital care have relied heavily on proxy measures of supply and use of posthospital services, with greater supply and more use taken to signify greater access.

We reported in 1983 that the growing need for nursing home care combined with constraints on the supply of nursing home beds had led to increasing problems for the elderly in gaining access to nursing home care.[1] PPS incentives for hospitals to increase their use of posthospital care were expected to exacerbate this problem. On the other hand, Medicare expenditures for skilled nursing facility (SNF) care have increased, in real terms, from an average of -0.3 percent between FY1973 and FY1982 to 7.0 and 4.2 percent respectively in the first two years after the implementation of PPS. Similarly, potential access to home health care is clearly on the upswing. The number of home health agencies has mushroomed and Medicare expenditures for this type of care continue to increase by over 20 percent per year.

However, these kinds of information do not shed light directly on the level of difficulty encountered by individuals attempting to gain access to posthospital services. The scant and fragmented evidence available from individual cases and surveys of providers

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[1] Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly, GAO/IPE-84-1 (Washington, D.C.: October 21, 1983), pp. iv-v.

indicates that serious problems have been encountered on occasion. No nationally representative information on the type or extent of problems in gaining access to posthospital care is available.

The Chairman of the Subcommittee on Health and Long-term Care, House Select Committee on Aging, requested that we survey a nationally representative sample of hospital discharge planners to obtain information on their experiences regarding access by Medicare patients to post-hospital care (see appendix I). They were also interested in the role of PPS and other factors in arranging access to posthospital care for the elderly. This briefing report presents the information reported by discharge planners on the following issues:

--What are the barriers to placing patients in skilled nursing facilities?

--What are the barriers to placing patients in home health care?

--How adequate is the supply of various types of posthospital care services, including skilled nursing homes and home health care?

--How has access to posthospital care changed since 1982? What effect have various events or trends (e.g., PPS) had on access to posthospital care?

OBJECTIVE, SCOPE, AND METHODOLOGY

The overall objective of this work was to obtain information on access to posthospital care of Medicare patients. Because of the difficulties in directly assessing access to care and the limited time available to develop the information, we defined access in terms of the difficulty involved in placing Medicare patients in appropriate posthospital care following hospital discharge. To obtain this information, we used a mail-in questionnaire to survey a stratified random sample of 985 Medicare-certified hospitals. The sampling approach and description of the responding hospitals are detailed in appendix II. The questionnaire used, summary data on the responses received, and sampling errors for key variables are included in appendix V.

We sent the questionnaire to the chief executive officer of each hospital with the request that it be directed to the individual in the hospital with primary responsibility for arranging posthospital placements--typically, a discharge planner. As a result, the information provided in this report represents the perceptions and opinions of a group of individuals who are directly responsible for helping patients gain access to posthospital care.

The questionnaire focused on access to posthospital care for Medicare beneficiaries. However, some limited information on hospital discharge planning processes was also requested. In

responding to specific questions about the posthospital placement of Medicare patients, the discharge planners were asked to limit their responses to Medicare patients about whom they had direct knowledge, including patients for whom no further care was found to be needed.[2] The questionnaire was designed to be completed in less than 30 minutes and require little or no information that would not be immediately available to the discharge planner. It contained primarily close-ended questions.

Several points about the interpretation of these results must be made. First, information provided by the discharge planners regarding Medicare patients refers only to those patients whom the discharge planner assisted in arranging posthospital care. Some discharge planners do not see all Medicare patients on a routine basis. Second, all of the data provided in this report should be taken to represent estimates based on the perceptions and experiences of the individuals surveyed. Our pilot test of the questionnaire indicated that verifiable figures on the number of Medicare patients receiving discharge planning, their discharge destinations, and other related outcomes either were not available or would require considerable effort to assemble in a uniform manner. In addition, verifiable data on these issues is not readily available from any other source. In the interests of obtaining high response rates in a short period of time, we asked the discharge planners to provide us with the best information that was immediately available to them.

DISCHARGE PLANNERS REPORT PROBLEMS IN ACCESS TO POSTHOSPITAL CARE[3]

Few discharge planners report having no problems in placing Medicare patients in posthospital care. Most report that Medicare patients face a number of important problems in gaining access to appropriate posthospital care. In general, discharge planners view Medicare program rules and regulations as the most important barrier to placing patients in both skilled nursing facilities and home health care. Based on discharge planners' comments, the category of Medicare program rules and regulations was used to represent two major issues: (1) a perception that the Medicare program has changed the way in which individual eligibility and

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[2]Appendix III examines the limited information that was collected on hospital discharge planning processes. Appendix IV provides estimates of the percentages of patients placed in particular post-hospital settings.

[3]Comparisons involving survey results throughout the report have been tested statistically and found significant at the 0.05 level of significance. This means that the likelihood of the result being due to chance alone is less than 1 in 20. In making comparisons, only differences judged to be important were tested for significance.

coverage determinations are made; and (2) a sense that posthospital benefits do not cover all of the types of services needed by the elderly. (See appendix VI for further information on the comments of the discharge planners.)

Almost all discharge planners report having problems placing Medicare patients in SNFs

Nationally, only 3 percent of discharge planners reported no problems in placing Medicare patients in skilled nursing facilities. The factor identified most frequently by the discharge planners as a barrier to SNF placement was Medicare program rules and regulations (71 percent). The availability of beds and need for complex skilled services (e.g., respirator care) were the next most frequently selected factors (63 percent). Of the factors listed on the questionnaire, the only factor selected by less than 50 percent of the discharge planners was the presence of chronic care needs (see table 1).

Table 1: Barriers to Placing Medicare Patients in Skilled Nursing Facilities[a]

Strata	Program rules and regulations: Medicare	Program rules and regulations: Medicaid	Supply of nursing home beds	Social or legal situation	Need for complex skilled care	Chronic care problems	Other factors	No problems
Region								
Northeast	66%	63%	62%	64%	71%	59%	21%	2%
South	67	56	80	59	72	48	16	1
East North Central	76	58	50	57	59	38	18	4
West North Central	72	58	54	30	56	30	12	6
West South Central	70	51	54	37	54	42	15	7
Mountain	76	50	34	42	39	29	15	4
Pacific	80	52	63	63	70	60	24	1
Population density								
Rural area	66	48	60	40	52	34	15	5
Small SMSA	73	58	64	54	68	44	18	3
Large SMSA	79	70	68	70	79	66	22	1
National	71	56	63	51	63	45	17	3

[a]Discharge planners were asked to check all of the factors that applied to their hospital.

Some regional patterns in discharge planners' views were apparent. Medicare program rules and regulations were identified as a barrier to placement less frequently by discharge planners in the Northeast and South than by discharge planners in the Pacific region. Discharge planners in the Northeast and South cited the supply of nursing home beds more frequently than did their counterparts in the other regions with discharge planners in the Mountain region being clearly the lowest. In terms of the social or legal situation of the patient (e.g., presence of family to assume financial responsibility), discharge planners in the West North Central, West South Central, and Mountain cited this barrier less frequently than discharge planners in the other regions. Discharge planners in the Northeast, South, and Pacific regions were more likely to cite the need for complex skilled care as a barrier than were discharge planners in the Mountain, West South Central and West North Central regions. Chronic care problems were more likely to be viewed as placement barriers by discharge planners in the Northeast and Pacific regions than by those in the

West North Central and Mountain regions with the remaining regions falling between those extremes.

With the exception of the supply of nursing home beds, discharge planners in large standard metropolitan statistical areas (SMSAs) more frequently cited each listed factor as an important barrier than did discharge planners in rural areas. The responses of discharge planners in small SMSAs were usually closer to those of their rural counterparts than to those in large SMSAs but the differences were not statistically significant.

Medicare program rules and regulations have the most effect on access to SNF care

When asked to select the most important barrier to placement in SNFs from those listed in table 1, the factor identified by the largest percentage of discharge planners nationally was Medicare program rules and regulations (33 percent). However, almost as many discharge planners (30 percent) identified the availability of skilled nursing home beds as most important. Fifteen percent of the discharge planners found the need for complex skilled care to be the most important factor. Few discharge planners found chronic care problems or the patient's social or legal situation to be the most important factor (see table 2).

Table 2: The Most Important Barrier to Placing Medicare Patients in Skilled Nursing Facilities[a]

Strata	Program rules and regulations		Supply of nursing home beds	Social or legal situation	Need for complex skilled care	Chronic care problems	Other factors
	Medicare	Medicaid					
Region							
Northeast	21%	12%	49%	1%	7%	4%	6%
South	26	10	39	5	13	3	3
East North Central	41	8	20	6	17	4	5
West North Central	49	0	28	4	13	3	3
West South Central	28	5	23	0	29	3	11
Mountain	52	7	19	5	13	0	4
Pacific	32	8	20	6	18	7	10
Population density							
Rural area	35	5	34	3	15	3	5
Small SMSA	32	9	29	4	17	4	6
Large SMSA	32	12	25	6	15	4	6
National	33	8	30	4	15	3	6

[a]As reported by the discharge planners.

A larger percentage of the discharge planners in the Mountain and West North Central regions identified Medicare program rules and regulations as the most important barrier to SNF placement than in the Northeast and South. In the latter regions, availability of nursing home beds was identified by a larger percentage than in the other regions except the West North Central. Approximately equal percentages of discharge planners in the West South Central region identified Medicare program rules and regulations and the need for complex skilled care as the most important factor. There were no statistically significant differences among the three population

density strata in terms of the most important barrier to SNF placement.

The availability of institutional posthospital care services is inadequate to marginal

We asked discharge planners for their opinion about the availability of three types of institutional posthospital services: skilled nursing beds, intermediate care (nursing home) beds, and rehabilitation centers.[4] Discharge planners in every region of the country reported that availability was less than adequate for all three services. The availability of skilled nursing and intermediate care beds was reported nationally to be between inadequate and marginal; the availability of rehabilitation centers was reported as almost marginal, indicating a neutral position with respect to adequacy (see figure 1).

In regions where discharge planners cited availability of beds as the most important barrier to SNF placement (i.e., the Northeast and South), their ratings of the availability of nursing home beds were considerably lower than those of discharge planners in other regions. The availability of rehabilitation facilities was judged less adequate by discharge planners in the South, West South Central, and Mountain regions and in rural areas than by discharge planners in the other regions and in urban areas.

Fewer discharge planners report problems in arranging home care for Medicare patients than in arranging SNF placement

Placing patients in home health care is a lesser problem according to discharge planners than SNF placements. Nationally, 14 percent of discharge planners reported having no problems arranging home health care for Medicare patients. Fewer discharge planners in the Northeast, South, Mountain, and Pacific regions reported having no problems arranging home health care than did discharge planners in the West South Central region (see table 3).

Of those discharge planners reporting specific barriers to arranging home health care for Medicare patients, 68 percent nationally identified Medicare program rules and regulations as an important barrier. Between 29 and 40 percent of discharge planners selected each of the remaining factors specified in the questionnaire. A similar pattern holds for each of the regions and population density strata: a large percentage of discharge planners selecting Medicare program rules and regulations relative to those identifying the remaining factors.

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[4]A five-point scale was used to obtain responses to the question about the availability of various posthospital services. The midpoint on that scale, labeled "marginal", was used as a neutral response.

Figure 1: Availability of Institutional Posthospital Care Services by Region and Population Density[a]

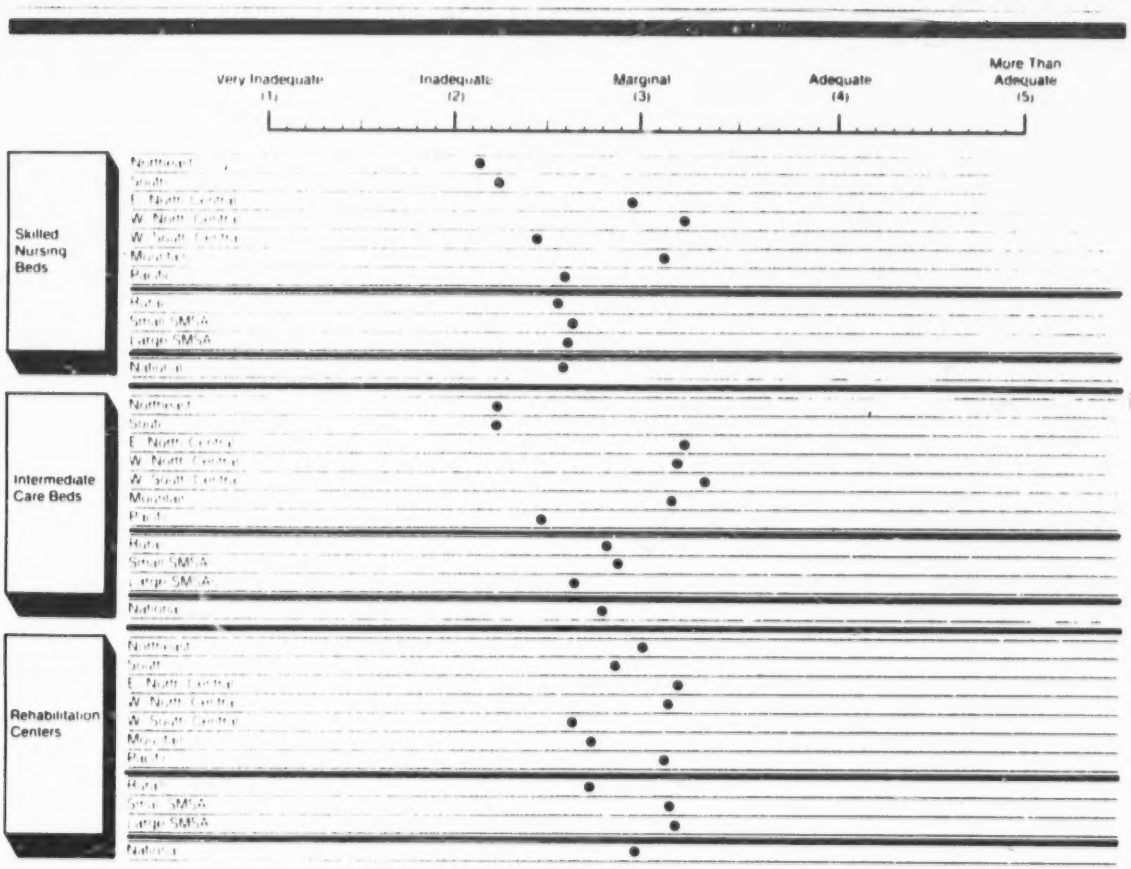


Table 3: Barriers to Placing Medicare Patients in Home Health Care[a]

Strata	Program rules and regulations: Medicare	Program rules and regulations: Medicaid	Supply of home health care	Social or legal situation	Need for complex skilled care	Chronic care problems	Other factors	No problems
Region								
Northeast	80%	35%	57%	50%	49%	61%	16%	4%
South	66	34	32	35	32	35	17	12
East North Central	67	36	21	33	31	39	18	20
West North Central	72	31	30	26	21	32	18	15
West South Central	62	44	14	28	30	36	13	24
Mountain	67	27	27	22	19	28	17	9
Pacific	66	38	19	37	38	41	23	11
Population density								
Rural area	62	32	30	27	26	31	15	18
Small SMSA	74	38	28	39	36	46	19	11
Large SMSA	75	40	29	42	43	50	20	10
National	68	36	29	34	33	40	17	14

[a]Discharge planners were asked to check all of the factors that applied to their hospital.

Only in the Northeast did more than half of the discharge planners identify a factor other than Medicare program rules and regulations as a barrier to home health care. In that region, the only factor identified by less than 49 percent of the discharge planners as a barrier was Medicaid program rules and regulations. Medicaid program rules and regulations were cited by 44 percent of discharge planners in the West South Central region. With the exception of availability of services and Medicaid program rules and regulations, the percentage of discharge planners citing each of the factors as a barrier to home health placement was larger in large SMSAs than in rural areas. This generally parallels the findings with respect to SNF placement: a larger percentage of discharge planners in large urban areas more often report problems.

Medicare program rules and regulations are the most important barrier to arranging home care

Nationally, over half of all discharge planners chose Medicare program rules and regulations as the most important barrier to arranging home health care for Medicare beneficiaries. This is considerably more than the 33 percent who chose it as the most important barrier to SNF placement. Availability of services was selected by the next largest group (13 percent). (See table 4.)

Table 4: The Most Important Barrier to Placing Medicare Patients in Home Health Care[a]

Strata	Program rules and regulations: Medicare	Program rules and regulations: Medicaid	Supply of home health care	Social or legal situation	Need for complex skilled care	Chronic care problems	Other factors
Region							
Northeast	54%	4%	18%	7%	2%	5%	11%
South	43	4	12	15	7	7	12
East North Central	54	2	12	9	7	8	10
West North Central	59	1	17	4	3	3	13
West South Central	50	9	6	2	12	7	14
Mountain	61	0	17	5	4	5	8
Pacific	51	2	10	11	8	6	11
Population density							
Rural area	48	4	17	9	7	5	11
Small SMSA	52	3	9	11	6	6	13
Large SMSA	59	3	11	6	5	7	9
National	52	4	13	9	6	6	11

[a]As reported by the discharge planners.

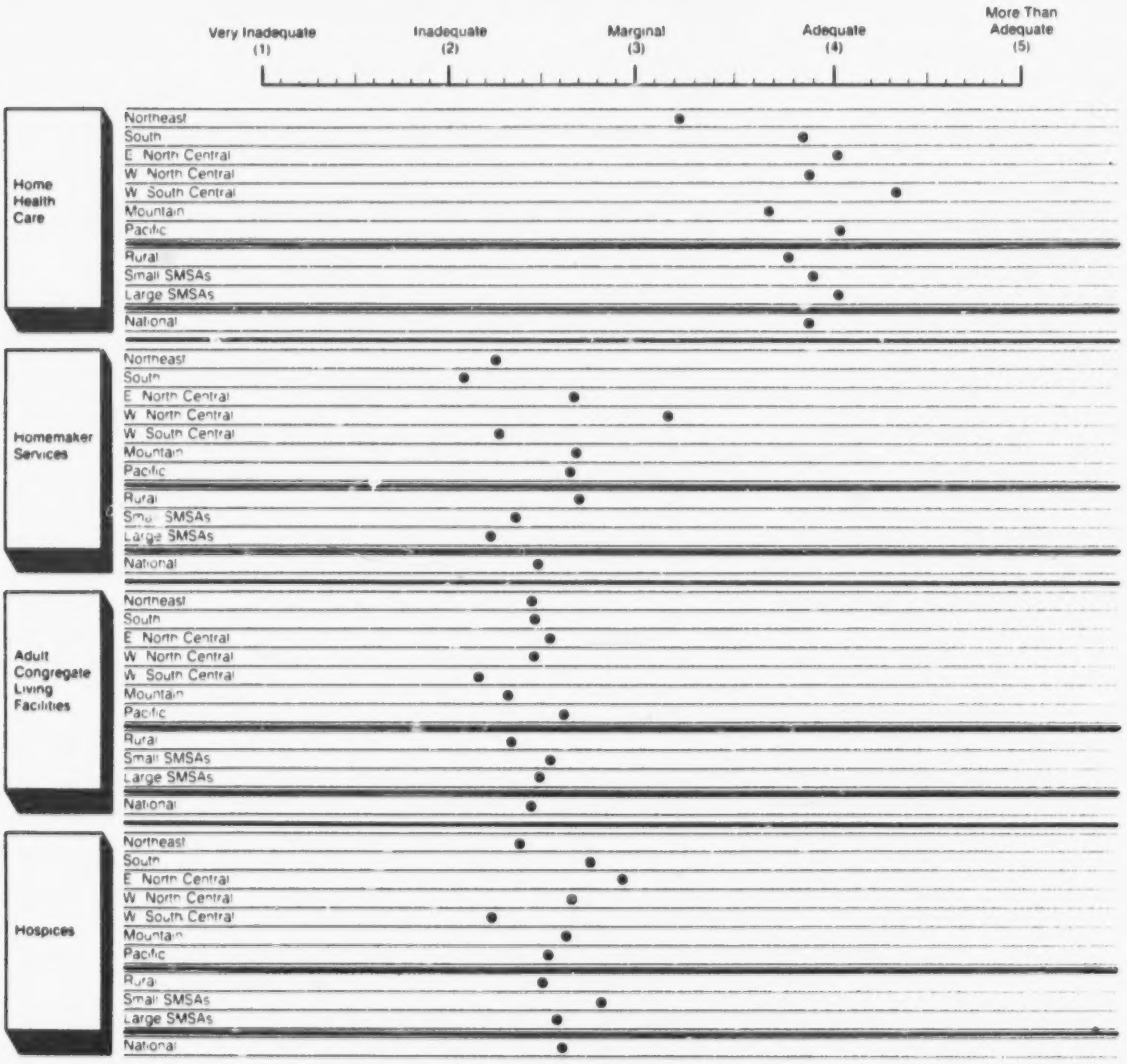
The percentage of discharge planners selecting Medicare program rules and regulations as the most important barrier was smallest in the South and largest in the West North Central and Mountain regions. Social or legal barriers were cited more frequently in the South than in the West North Central, West South Central, and Mountain regions. Availability was relatively more troublesome in the West North Central, Mountain, and Northeast regions than in the West South Central region. The only statistically significant difference among the population density strata in the relative importance of the individual factors was

between rural areas and small SMSAs in terms of the supply of home health care.

The availability of noninstitutional posthospital services varies

Discharge planners' perceptions regarding the availability of various noninstitutional posthospital services such as home health care and adult group living are presented in figure 2. The

Figure 2: Availability of Noninstitutional Posthospital Care Services by Region and Population Density[a]



[a] • represents the average response of discharge planners

availability of home health care is generally regarded as adequate nationally. Only in the Northeast is availability close to marginal. On the other hand, the supply of homemaker services, hospice, and adult congregate living is viewed as between inadequate and marginally adequate nationally.

DISCHARGE PLANNERS REPORT ACCESS TO POSTHOSPITAL CARE MORE DIFFICULT IN 1985 THAN IN 1982

More than half of the discharge planners across the nation reported that the percentage of Medicare discharges who had to wait in the hospital because access to appropriate posthospital care was not immediately available was greater in 1985 than in 1982 (see table 5). An extended hospital stay has potentially significant

Table 5: Change in the Percent of Medicare Discharges Waiting in the Hospital for Placement in Posthospital Settings[a]

Strata	Number of respondents[b]	Greater than 1982[c]	No difference or less than 1982[d]
Region			
Northeast	105	59%	41%
South	94	67	33
East North Central	78	59	41
West North Central	67	41	59
West South Central	71	55	45
Mountain	57	51	49
Pacific	80	43	57
Population density			
Rural area	170	57	43
Small SMSA	182	54	46
Large SMSA	200	58	42
National	552	56	44

[a]For nospitals wnere patients had to wait for placement in 1985.
[b]Actual number of discnarge planners responding; tne question was answered only by discharge planners in hospitals currently experiencing problems in placing patients. The percentages are, however, weignted.
[c]Based on responses of "much greater" and "somewhat greater" on a five-point scale.
[d]Based on responses of "no difference," "somewnat less," and "much less" on the five-point scale.

financial implications for hospitals, because under PPS, hospitals only receive extra payments for extended hospital stays if the patient's length of stay exceeds tne PPS "day outlier" criteria.

Prior to the implementation of Medicare prospective payment in October 1983, hospitals were reimbursed on a per-diem basis for care provided to patients waiting for nursing home placement. Therefore we believe that responses to this question may reflect, in part, the heightened awareness of the need to discharge patients under PPS. In part, the responses may also reflect an increase in the number of patients who are competing for the available nursing home beds.

There was considerable regional variation in the reported change in the percentage of patients awaiting placement in appropriate posthospital care. In the Northeast, South, and East North Central regions, 59 percent or more of the discharge planners reported that the percentage of patients was greater. In two regions, the West North Central and Pacific, the majority of discharge planners reported no difference or a decrease in the percent of patients waiting. (Additional information on the percent of patients waiting in hospitals for posthospital care can be found in appendix IV.)

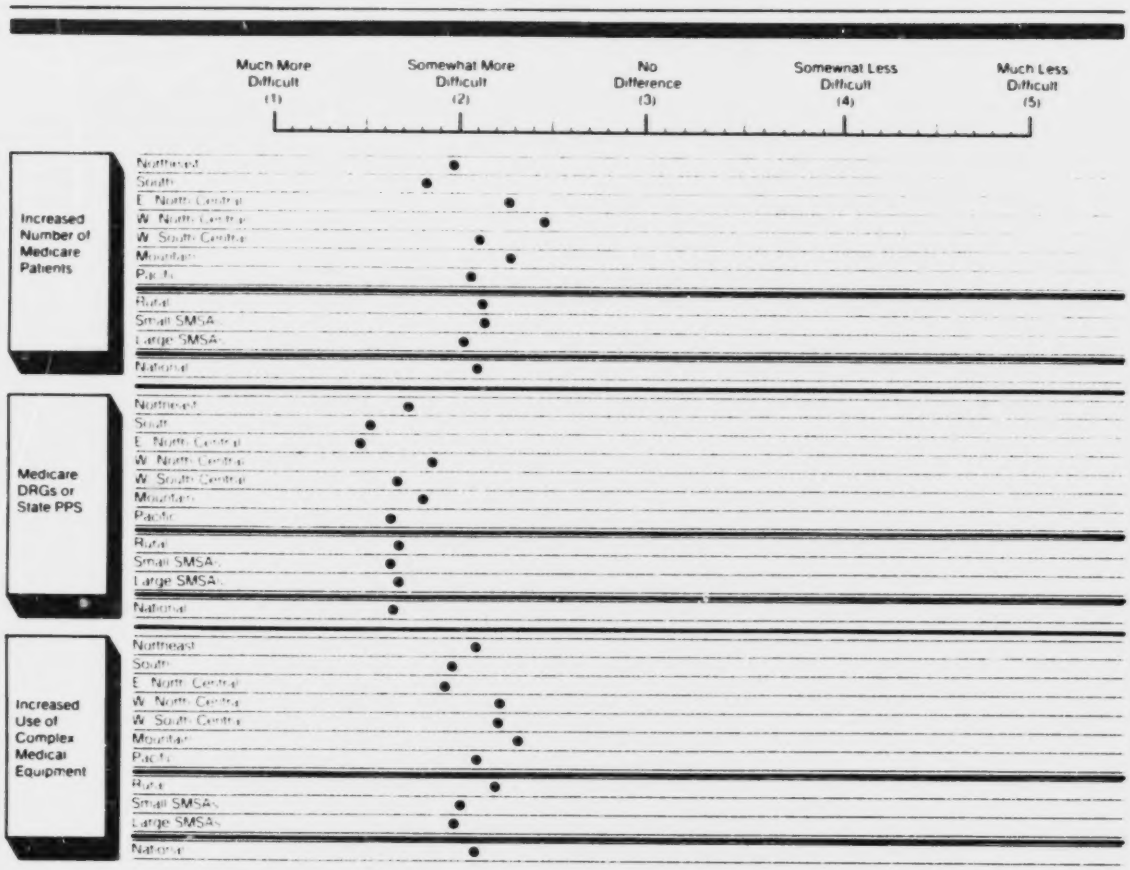
There was little variation in responses of discharge planners across the three population-density groups. Fifty-eight percent of discharge planners from hospitals in large SMSAs reported that the percentage of patients awaiting placement was greater in 1985 than in 1982; 57 percent of discharge planners from hospitals in rural areas and 54 percent of discharge planners from hospitals in small SMSAs responded similarly.

Prospective payment is a major factor in making access to posthospital care more difficult

Potential trends or events since 1982 that could affect access to posthospital care are shown in figure 3 on pages 16-17. The introduction of Medicare or state-sponsored prospective payment systems was seen as contributing greatly to access difficulties. With one exception, all other factors were reported as having roughly the same effect on access, making it somewhat more difficult to place Medicare patients in posthospital care. These include increased number of Medicare patients, increased use of complex medical equipment and other "high-tech" services in posthospital care, state certificate-of-need regulation of nursing home beds, and changes in the number of certified SNF beds. Growth in the number of home health agencies was rated as making placement of patients somewhat less difficult.

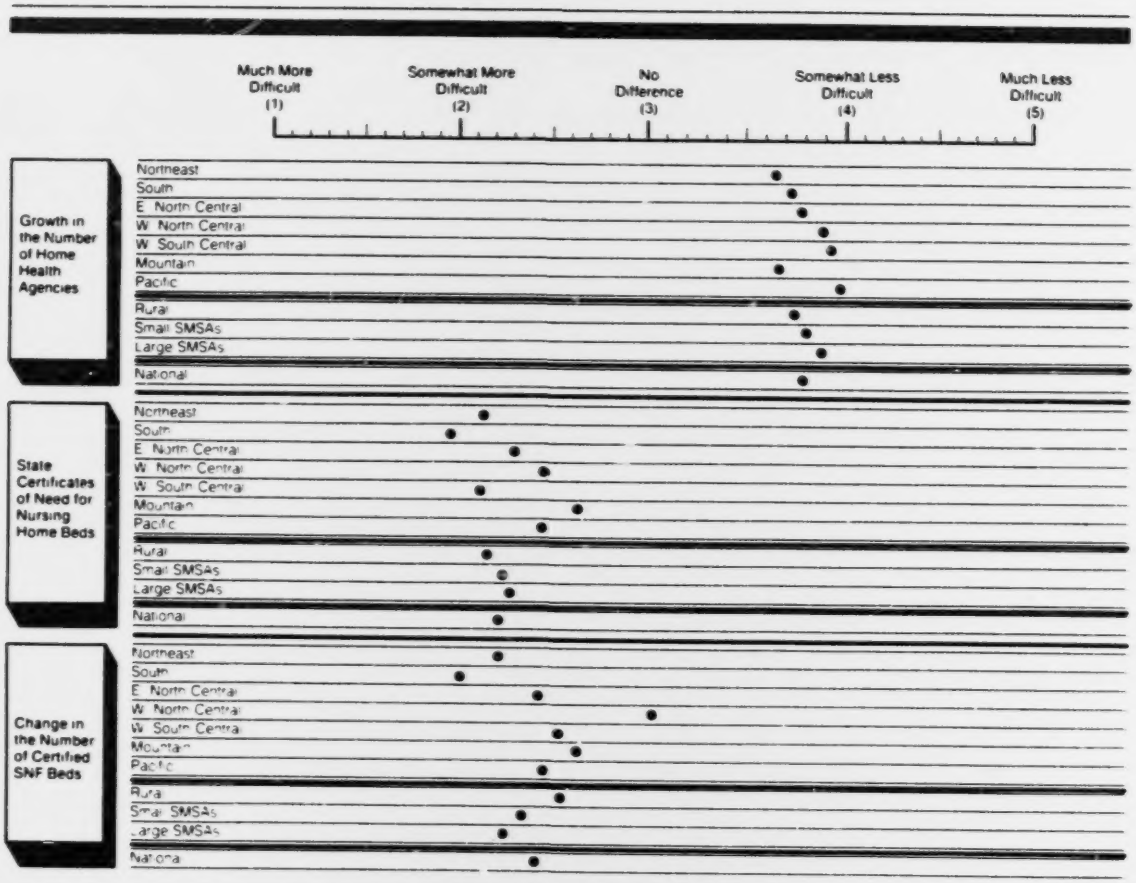
In general, discharge planners in the South rated the individual factors as having made larger, negative changes in access to posthospital care than did discharge planners in the rest of the country. On the other hand, discharge planners in the West North Central region generally rated the individual factors as having had smaller effects than did discharge planners in the other regions.

Figure 3: Trends and Events Since 1982 That Could Affect Access to Posthospital Care by Region and Population Density•



• represents the average response of discharge planners

Discharge planners in rural areas reported that state certificate-of-need regulation of nursing home beds affected them to a greater extent than did discharge planners in either SMSA group. Conversely, discharge planners in rural areas reported that the increased use of complex durable medical equip-



' • represents the average response of discharge planners

ment and other "high-tech" services and changes in the numbers of certified SNF beds had less effect on access than did discharge planners in SMSAs. Overall, the differences among the population density groups were smaller than between the regions of the country.

SUMMARY

The results of our survey of a nationally representative sample of hospital discharge planners showed that, for patients whose need for posthospital care has been ascertained by hospital professionals:

--Most discharge planners believe that one or more barriers to the placement of Medicare patients in posthospital care exist. Nationally, only 3 percent of discharge planners reported no problems in placing patients in SNF care; 14 percent reported no problems in home health care placements.

--The most important barrier to the placement of Medicare beneficiaries in both skilled nursing facilities and home health care as reported by discharge planners is Medicare program rules and regulations. The availability of skilled nursing beds is next in importance as an important barrier to SNF placement. For home health placement, no factor other than Medicare rules and regulations is considered as "most important" by a large percentage of discharge planners.

--Discharge planners believe that access to posthospital care for Medicare patients is generally more problematic now than it was in 1982. Discharge planners report that percentage of patients waiting in the hospital for appropriate posthospital placement has increased.

--According to the discharge planners, a variety of factors have contributed to increased problems in access to posthospital care. The implementation of PPS and the incentives it gives hospitals to discharge patients as soon as is medically appropriate is consistently singled out by discharge planners as a major factor making the placement of Medicare patients more difficult. The growth in the number of home health agencies is regarded as facilitating posthospital placements.

--Regional variations exist in reported problems with access to posthospital care. Discharge planners in the Northeast, South, and East North Central are more likely than their peers in the West North Central and Pacific regions to report increases in the percentage of patients awaiting posthospital placement now than in 1982. Unlike discharge planners in most other regions, a greater proportion of the discharge planners in the Northeast and South cited the availability of skilled nursing beds as the most important barrier to SNF placement. Discharge planners in each of the regions cited Medicare program rules and regulations as the most important barrier to home health placement.

--In general, the proportion of discharge planners who cited each barrier as an important factor generally increased as population density increased. Population density did not seem to be systematically related to reported changes between 1982 and 1985 in the percent of Medicare patients awaiting posthospital placement or to the selection of Medicare program rules and regulations as the most important barrier to SNF placements.

REQUEST LETTER

CLAUDE PEPPER FLORIDA
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U.S. House of Representatives
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January 3, 1986

Dear Mr. Bowsher:

Your assistance in a matter of great importance to the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging would be most appreciated.

As a part of its ongoing reveiw of the impact of Medicare's new prospective payment system on long-term care services available to older Americans, the Subcommittee would like to request that your Program Evaluation and Methodology Division conduct a survey of discharge planners in hospitals that are operating under the Medicare prospective payment system. It is our understanding that the Division is currently completing a study designed to identify approaches for evaluating the effects of the new payment system on post-hospital care.

The Subcommittee would like to obtain information on the experiences of discharge planners with the placement of Medicare patients in post-hospital care, including nursing homes, home health, and community services. We would like to get this group's perceptions of the factors that are related to difficulties in placing patients such as source of payment, type and intensity of care required and supply of services. The Subcommittee is also interested in discharge planners' opinions regarding the role of PPS and other factors such as the supply of services and type of payment in arranging post-hospital placement of elderly patients. In order for this information to extend our current knowledge on these important issues, we feel that the survey should provide nationally representative data on these topics.

The Subcommittee would like a briefing on the intitial results of the survey in early August of this year. We recognize that this is a relatively short timeframe for such a project. We understand, therefore, that the information provided at the August briefing will be supplemented by a final report at a later time.

If you or your staff have any questions related to this request, please contact Peter Reinecke of the Subcommittee staff at 226-3381.

With kindest regards,

Very sincerely,

Claude Pepper
Chairman

The Honorable Charles Bowsher
Comptroller General of the
United States
441 G Street, N.W.
Washington, D.C. 20548

CP:pgr

SAMPLING PLAN AND DESCRIPTION OF RESPONDING HOSPITALS

In the following sections, we present the sampling plan used in this study and describe the hospitals that responded to the questionnaire. The questionnaire was mailed to a stratified random sample of hospitals with instructions that it should be completed by the hospital discharge planners. The data collection was done between March and June 1986. Individuals not responding to the initial mailing were sent two waves of follow-up questionnaires to encourage response. Overall, 93 percent of the hospitals returned questionnaires.

SAMPLE OF HOSPITALS

The sample of hospitals was designed to be nationally representative of all Medicare-certified hospitals under PPS or state-sponsored prospective payment systems. It was drawn from a list of hospitals maintained by the American Hospital Association, which includes hospitals in the United States and its associated areas (American Samoa, Guam, the Marshall islands, Puerto Rico, and the Virgin Islands). The universe was restricted to nonfederal Medicare-certified, short-stay hospitals in the 50 states and District of Columbia.[1] Short-stay hospitals are those with average lengths of stay under 30 days. Hospitals were divided into seven areas of the country based on census regions and within each region into three strata based on the population density of the area in which the hospital was located. Roughly 50 hospitals were randomly sampled from each of the resulting 21 strata with a total original sample of 985 hospitals. (See table II.1 for definitions of the strata and sample and universe sizes.)

An adjustment had to be made to the original sample of hospitals based on responses to the survey. Five percent of the sample are rehabilitation, psychiatric (including mental retardation and chemical dependency), and pediatric hospitals. While the response rate for these hospitals was similar to the overall rate, many of their questionnaires were returned with an explanation that the questions were only marginally relevant to their patient populations. Therefore, these hospitals are excluded from the analyses. Of the remaining 95 percent, 93 percent of the sample are general medical-surgical hospitals and 2 percent are other specialty hospitals serving all ages. These 935 hospitals are included in the overall analyses. (The revised population and sample sizes are presented in table II.1.)

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[1] The description of the characteristics of the sampled hospitals is based on the AHA definitions which can be found in American Hospital Association, Hospital Statistics (Chicago, American Hospital Association, 1985).

Table II.1: Survey Sampling Plan[a]

Census region	Population density[b]					
	Rural		Small		Large	
	Original	Revised	Original	Revised	Original	Revised
1+2 New England/ Mid Atlantic (ME, NH, VT, MA, RI, CT, NY, NJ, PA)[c]	195/48	193/47	312/48	301/48	367/48	347/45
3+5 South Atlantic/ East South Central (DE, MD, DC, VA, WV, NC, SC, GA, FL, KY, TN, AL, MS)[d]	688/49	685/49	444/49	403/43	233/48	213/43
4 East North Central (OH, IN, IL, MI, WI)	377/49	370/48	274/48	260/44	280/48	260/45
6 West North Central (MN, IA, MO, ND, SD, NE, KS)	603/49	600/49	137/48	130/46	68/34	61/30
7 West South Central (AR, LA, OK, TX)	461/49	459/49	245/48	229/44	142/48	133/47
8 Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	269/48	265/48	74/37	65/31	45/45	41/40
9 Pacific (WA, OR, CA, AK, HI)	169/48	169/48	186/48	176/45	389/48	346/46

[a]Tabled values are the number of hospitals in the population over the number of hospitals in the sample.
[b]Rural areas include all nonSMSA areas. Small SMSAs are defined as SMSAs with a population of up to 1,000,000. Large SMSAs are defined as SMSAs with populations over 1,000,000.
[c]Referred to in the body of the report as the Northeast region.
[d]Referred to in the body of the report as the South region.

Unless otherwise indicated, weighted analyses based on the revised sample are reported. Ninety-three percent (866) of the revised sample of hospitals responded to the survey; response rates in each of the individual strata exceeded 80 percent. All sample surveys are subject to sampling error, which reflects the extent to which the sample results may differ from results that would be obtained if the entire population had responded to the same questionnaire. Our sample was designed to have sampling errors of no more than three percentage points at the 95-percent level of confidence (sampling errors for subsets of the sample could be higher). We calculated the actual sampling errors for selected key variables; these appear in parentheses below the weighted national responses for those variables in appendix V.

DESCRIPTION OF THE RESPONDING HOSPITALS

Sixty-two percent of the responding hospitals are nongovernment, not-for-profit hospitals which include private not-for-profit and church-operated not-for-profit hospitals. Twenty-five percent of the sampled hospitals are nonfederal, government-controlled hospitals including hospitals controlled by state and local governments, hospital districts, and other public entities.

Thirteen percent are nongovernment, for-profit hospitals. Thirty-eight percent of the hospitals have fewer than 100 beds, 39 percent have between 100 and 299 beds, and 24 percent have 300 or more beds (see table II.2).

Table II.2: Characteristics of the Responding Hospitals

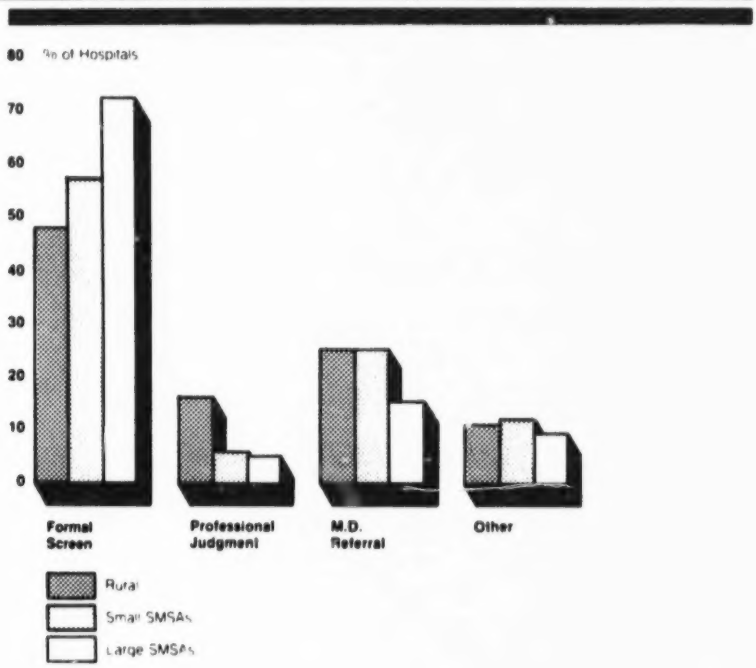
Strata	Number of hospitals	Bedsize Range	Bedsize Percentage	Control Types	Control Percentage
Region					
Northeast	133	< 100	30.1%	Nonfederal government	6.0%
		100-299	40.6	Private not-for-profit	88.7
		300+	29.3	For-profit	5.3
South	124	< 100	26.6	Nonfederal government	24.2
		100-299	44.4	Private not-for-profit	54.8
		300+	29.0	For-profit	21.0
East North Central	134	< 100	33.6	Nonfederal government	19.4
		100-299	38.8	Private not-for-profit	78.4
		300+	27.6	For-profit	2.2
West North Central	118	< 100	42.4	Nonfederal government	35.6
		100-299	32.2	Private not-for-profit	61.0
		300+	25.4	For-profit	3.4
West South Central	126	< 100	46.0	Nonfederal government	37.3
		100-299	35.7	Private not-for-profit	35.7
		300+	18.3	For-profit	27.0
Mountain	111	< 100	38.7	Nonfederal government	23.4
		100-299	34.2	Private not-for-profit	67.6
		300+	27.0	For-profit	9.0
Pacific	120	< 100	46.7	Nonfederal government	30.8
		100-299	45.0	Private not-for-profit	46.7
		300+	8.3	For-profit	22.5
Population density					
Rural areas	308	< 100	67.9	Nonfederal government	37.7
		100-299	29.2	Private not-for-profit	55.5
		300+	2.9	For-profit	6.8
Small SMSA	289	< 100	24.6	Nonfederal government	21.1
		100-299	45.3	Private not-for-profit	66.4
		300+	30.1	For-profit	12.5
Large SMSA	269	< 100	16.7	Nonfederal government	14.5
		100-299	42.8	Private not-for-profit	65.4
		300+	40.5	For-profit	20.1
National	866	< 100	37.5	Nonfederal government	24.9
		100-299	38.8	Private not-for-profit	62.2
		300+	23.7	For-profit	12.8

SUMMARY OF RESPONSES TO QUESTIONS ABOUT THE DISCHARGE PLANNING PROCESS

Although discharge planning has only recently been incorporated as a condition of participation in the Medicare program, it is clear from the responses to our survey that most hospitals across the country have some form of discharge planning function. Seventy-nine percent of discharge planners have held their current jobs for more than 1 year. Of discharge planners who have held their job for less than 6 months, 68 percent are in rural hospitals. Of those who have been there 6 months to 1 year, 57 percent are in rural hospitals.

Fifty-six percent of discharge planners report that some form of formal screening process for discharge planning for Medicare beneficiaries is used at or soon after admission. Twenty-three percent report that physicians are the primary source of referrals for discharge planning. Ten percent report that they use their professional judgement to identify patients needing discharge planning. Eleven percent indicate that some combination of the above approaches is used. Formal screening of admissions is most often used in urban hospitals (see figure III.1). Of hospitals

Figure III.1: Primary Discharge Planning Methods by Area



where discharge planners have the primary responsibility for locating patients needing posthospital care, 73 percent were in rural hospitals. Similarly, 84 percent of hospitals where physicians have primary responsibility for referrals are in rural areas or small SMSAs. Regarding the reasons patients are referred for discharge planning, roughly 90 percent of discharge planners cite three reasons: social or legal situation, 93 percent; specific diagnoses, 90 percent; and chronic care problems, 87 percent). Thirty percent also cite other reasons.

Nationally, 35 percent of discharge planners report that follow-up contacts regarding discharged Medicare patients are made in half or more of the cases (see table III.1). Seventeen percent

Table III.1: Relative Frequency of Posthospital Contact With Medicare Patients by Discharge Planners

Strata	Seldom, if ever	Sometimes	About half the time	Most of the time	Almost always
Region					
Northeast	16%	52%	11%	14%	7%
South	18	41	19	14	8
East North Central	15	59	10	10	5
West North Central	21	44	17	14	4
West South Central	15	39	16	17	13
Mountain	13	54	15	13	4
Pacific	21	52	14	7	6
Population density					
Rural area	19	42	16	15	8
Small SMSA	18	52	14	12	5
Large SMSA	12	55	13	12	8
National	17	48	15	13	7

of the discharge planners report that follow-up contacts are seldom, if ever, made. The frequency of follow-up contact ranges from around 25 percent of discharge planners in the Pacific and East North Central regions reporting follow-up contacts in half or more of cases to 46 percent of discharge planners in the West South Central region.

For discharge planners reporting that they make follow-up contacts at least sometimes, 70 percent indicate that they use telephone contacts with the patient or family or contacts with the posthospital provider (see table III.2). Only seventeen percent report visiting the patient. The same pattern holds across regions and population density groups.

Table III.2: Type of Posthospital Contact With Medicare Patients by Discharge Planners[a]

Strata	Patient visits	Telephone contacts	Contacts with providers
Region			
Northeast	20%	78%	80%
South	15	72	75
East North Central	15	76	78
West North Central	20	60	63
West South Central	17	71	63
Mountain	19	60	68
Pacific	18	64	76
Population density			
Rural area	18	64	67
Small SMSA	14	72	73
Large SMSA	20	79	81
National	17	70	72

[a]For those discharge planners making follow-up contacts in at least some cases.

INFORMATION ON PATIENTS WAITING IN THE HOSPITAL FOR PLACEMENT AND ON DISCHARGE DESTINATIONS

Discharge planners were asked to estimate (1) the proportion of patients who had to stay in the hospital for varying periods of time awaiting placement in posthospital care, and (2) the proportion of patients they assisted with posthospital placement who were discharged to particular posthospital settings in their fiscal year 1985. Pretesting of the questionnaire indicated that obtaining actual counts of patients would either not be possible or would require substantial effort on the part of the discharge planners. As a result, the discharge planners' estimates of percentages of patients cannot and should not be converted into numbers of patients.

In addition, median percentages are reported rather than means. The median is a better representation of central tendency than the mean because of the skewed distributions found for these variables. The median percentage can be interpreted as meaning that half of the discharge planners estimated that their hospitals sent that percentage or more of the Medicare patients seen by its discharge planners to a particular posthospital setting and that half sent that percentage or fewer.

ESTIMATES OF HOW LONG PATIENTS WAIT IN THE HOSPITAL FOR PLACEMENT IN POSTHOSPITAL CARE

Some patients cannot be discharged from acute care as soon as a physician indicates their readiness because appropriate posthospital care is not available. When the posthospital placement involves a skilled nursing facility, the days that patients spend in the hospital waiting for a Medicare or Medicaid nursing home bed have been termed "alternative placement days" or "administratively necessary days". National data on the number of patients waiting in hospitals for nursing home placement and the time spent waiting is very limited.[1]

Prior to the implementation of Medicare prospective payment, hospitals were reimbursed for their costs on a per diem basis, and in many cases, care for patients waiting for nursing home placement was reimbursed at the full Medicare hospital per diem rate. Under PPS, hospitals only receive extra payments for these extended hospital stays if the patient's length of stay exceeds the "day outlier" criteria.[2] Therefore, patients waiting in hospitals for

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[1]GAO-IPE-84-1.

[2]However, the prePPS costs of maintaining patients in the hospital while they waited for a nursing home bed can be presumed to have been built into the DRG rate because they were not removed when the rates were set. Thus, in effect, hospitals receive payment under PPS for "alternative placement days".

appropriate posthospital care have become a greater focus of attention for hospitals.

The length of time patients waited in hospitals for planned posthospital placements as estimated by discnarge planners is summarized in table IV.1. Nationally, the median percent of a hospital's Medicare discharges receiving discharge planning who left the hospital when the physician approved was 93 percent; 3 percent waited more than two days. One percent had to wait more than one week.

Table IV.1: Estimated Lengtn of Time Patients Waited in Hospitals for Posthospital Placements[a]

Strata	Left hospital when physician approved	Waited 2 days or less	Waited 3 to 7 days	Waited more than 7 days
Region				
Northeast	80%	4%	5%	5%
South	80	5	5	3
East North Central	95	2	1	0
West North Central	98	1	0	0
West South Central	95	3	1	0
Mountain	100	0	0	0
Pacific	91	4	2	1
Population density				
Rural area	95	3	1	0
Small SMSA	92	3	2	1
Large SMSA	90	4	3	1
National	93	3	2	1

[a]Median percent of a nospital's Medicare discharges.

The percent of patients who were released from the hospital when their physician approved was considerably lower in the Northeast and South regions than in the other regions with only 80 percent being estimated as released on time. In the remaining regions, the estimates were over 90 percent released on time. Hospitals in urban areas tended to have a somewhat greater percent waiting than rural hospitals but the differences were not statistically significant.

WHERE DO PATIENTS GO?

Nationally, discharge planners reported that only about 37 percent of a hospital's discharges were discharged to their homes without further care (see table IV.2 on page 30). This percent is considerably smaller than estimates based on Medicare administrative data. According to the 1984 HHS annual report on the impacts of PPS, 91 percent of discharges went home without further care. While we cannot be sure of the reasons for this

Table IV.4: Posthospital Destination of Medicare Discharges[a]

Strata	Home: Without further care	Home: With home health care	Skilled nursing facilities	Intermediate care facilities	Group living facilities	Rehabilitation centers
Region						
Northeast	29%	34%	10%	6%	1%	2%
South	25	25	15	10	1	1
East North Central	40	25	15	10	0	1
West North Central	35	20	14	15	0	1
West South Central	40	25	5	10	0	1
Mountain	50	18	10	5	0	1
Pacific	47	22	15	2	2	2
Population density						
Rural area	40	21	10	10	0	0
Small SMSA	32	28	12	10	1	2
Large SMSA	35	28	13	5	1	3
National	37	25	12	10	0	1

[a]Median percent of a hospital's Medicare discharges receiving discharge planning who were discharged to a particular posthospital setting.

discrepancy, three possibilities seem likely. First, we asked the discharge planners to provide us with information only for those patients they helped place in posthospital care. Discharge planners may not have information on patients who were simply discharged home; including those patients would have increased the percentage discharged home without further care. Second, some of the patients may have paid for their own posthospital care. These patients would not appear in the Medicare program statistics but would be included in the discharge planners estimates of patients receiving posthospital care. Third, we have previously reported that discharge destination information derived from hospital discharge abstract data does not accurately reflect all posthospital care placements.[3]

Most formal posthospital care is provided by home health agencies or nursing homes. Discharge planners estimated that about 25 percent of hospital discharges seen by them receive home health care. About 22 percent receive care in either skilled or intermediate care nursing homes. Hospitals in the Northeast reported sending a higher percentage of their discharged patients to home health care than hospitals in other regions. Rural hospitals are less likely to discharge patients to home health care than are hospitals in urban areas.

Hospitals in the West South Central region reported a lower percentage of discharges to skilled nursing care than hospitals in other regions; hospitals in the Northeast, Mountain and Pacific regions send a lower percentage to intermediate care facilities. Population density appears to be less important than region of the country in determining variation in discharges to nursing homes; rural hospitals reported somewhat more that patients went home without further care.

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[3]GAO/PEMD-85-8.

QUESTIONNAIRE ANNOTATED WITH SUMMARY RESPONSE DATA AND SAMPLING ERRORS FOR KEY VARIABLES

This is a reproduction of the questionnaire used in the study. We have inserted weighted summary response information for each of the questions. In addition, for key questions, survey sampling errors are included in parentheses with the response information.

Medicare Patients Access to Post Hospital Care: Survey of Hospital Discharge Planners

The U.S. General Accounting Office, an agency of the Congress, is conducting a survey of hospital discharge planners at the request of the House Select Committee on Aging, Subcommittee on Health and Long-term Care. The survey is focused on factors influencing access to post-hospital care for Medicare beneficiaries. Please return the completed questionnaire in the attached envelope to W. Holloway, US General Accounting Office, Room 5844, 441 G Street N.W., Washington, D.C. 20548.

Start card 1 (1)

I.D. No. _____ (2-4)

1. How long have you worked as a discharge planner for this hospital? **(Check one)**

   1. [8%] Less than six months
   2. [13%] Six months to one year
   3. [78%] More than one year

   (1%) Did not respond

(6)

2. What is the primary method used by your hospital to determine which **Medicare** patients receive discharge planning services? **(Check one)**

   1. [52%] Formal screening at or soon after admission
   2. [10%] Professional judgment of discharge planner
   3. [21%] Referral by attending physician
   4. [10%] Other, please specify

   _____

   _____

   5. [-] Don't know

   (7%) Multiple Responses

   (-) Did not Respond

(7)

APPENDIX V

3. What factors determine which **Medicare** patients are referred for discharge planning? **(Check all that apply)**

1. [93%] Social or legal situation (e.g., living conditions, family situation, guardianship, conservatorship) (8)

2. [90%] Specific diagnosis (e.g. stroke, heart attack, hip fracture) (9)

3. [87%] Chronic care problems (e.g. Alzheimer's disease, pulmonary problems, incontinence) (10)

4. [30%] Other, please specify (11)

_____

5. [-] Don't know (12)

4. For **Medicare** patients you helped place in fiscal year 1985, please estimate the percentage who were discharged to the following post hospital care locations. **The total should equal 100 percent.**

(median)

37% Home without further care. (13-14)

25% Home with home health care (Medicare/Medicaid). (15-16)

12% Skilled nursing facility. (17-18)

10% Intermediate care facility. (19-20)

0% Group living facility. (21-22)

1% Rehabilitation center. (23-24)

0% "Other" facility. Please specify, _____ (25-26)

(5%) Did not respond

5. For **Medicare** patients you helped place in fiscal year 1985, please estimate the percentage who waited for discharge due to a lack of available post hospital care services. (median)

5% Percentage who waited for discharge **(If 0, skip to 8)** (28-29)

(8%) Did not respond

6. In your opinion, was the percentage of **Medicare** patients who waited for discharge in fiscal year 1985 due to a lack of post hospital care services much greater, the same, or much less than the percent who waited in 1982? **(Check one)**

1. [16%] Much greater than 1982
2. [1%] Somewhat greater than 1982 (4.7%)
3. [11%] No difference (31)
4. [10%] Somewhat less than 1982 (4.7%)
5. [6%] Much less than 1982

6. [13%] Don't know/No opinion

(24%) Skipped because of question 5

7. For **Medicare** patients you helped place in fiscal year 1985, please estimate the percentage who were released when the doctor approved discharge and the percentage who waited 2 days or less, 3 days to a week, and more than a week for discharge to post hospital care services. **The total should equal 100 percent.**

(median)

93% Percentage of **Medicare** patients released when the doctor approved. (33-34)

3% Percentage of **Medicare** patients who waited "2 days or less" for post hospital care services. (35-36)

2% Percentage of **Medicare** patients who waited "3 days to a week" for post hospital care services. (37-38)

1% Percentage of **Medicare** patients who waited "more than a week" for post hospital care services. (39-40)

(9%) Did not respond

8. Which, if any, of the following factors make it difficult to place Medicare patients in skilled nursing facilities? (Check all that apply)

1. [71%] Medicare program rules and regulations (41)
   (3.2%)
2. [56%] Medicaid program rules and regulations (42)
   (3.5%)
3. [63%] Availability of nursing home beds (43)
   (3.2%)
4. [51%] Social or legal situation (e.g., (44)
   (3.4%) living conditions, family situation, guardianship, conservatorship)
5. [63%] Need for complex and/or skilled services (45)
   (3.3%) (e.g. feeding pumps, IV's, respirators)
6. [45%] Chronic care problems (e.g. Alzheimer's (46)
   (3.3%) disease, pulmonary disease, incontinence)
7. [17%] Other, please specify (47)

---

8. [3%] No problems arranging for skilled nursing placements (Skip to 10)
   (1.3%) (48)

9. Of those factors selected in question 8, which factor has had the most impact on your ability to place Medicare patients in skilled nursing facilities? (Check one)

1. [29%] Medicare program rules and regulations
   (3.5%)
2. [7%] Medicaid program rules and regulations (49)
   (1.9%)
3. [26%] Availability of nursing home beds
   (3.5%)
4. [3%] Social or legal situation (e.g.,
   (1.4%) living conditions, family situation, guardianship, conservatorship)
5. [14%] Need for complex and/or skilled services
   (2.7%) (e.g., feeding pumps, IV's, respirators)
6. [3%] Chronic care problems (e.g., Alzheimer's
   (1.4%) disease, pulmonary disease, incontinence)
7. [5%] Other, please specify

(8%) Multiple response

(5%) Did not respond/skip from 08

10. Which, if any, of the following factors make it difficult to arrange home care (home health care, homemaker services, etc.) for **Medicare** patients? **(Check all that apply)**

1. [68%] **Medicare** program rules and regulations (50)
   (3.3%)
2. [36%] **Medicaid** program rules and regulations (51)
   (3.3%)
3. [29%] Availability of home care services (52)
   (3.1%)
4. [34%] Social or legal situation (e.g., (53)
   (3.2%) living conditions, family situation, guardianship, conservatorship)
5. [33%] Need for complex and/or skilled services (54)
   (3.2%) (e.g. feeding problems, IV's, respirators)
6. [40%] Chronic care problems (e.g. Alzheimer's (55)
   (3.3%) disease, pulmonary disease, incontinence)
7. [17%] Other, please specify (56)

   _____

8. [14%] No problems arranging home care **(Skip to 12)** (57)
   (2.5%)

11. Of those factors selected in question 10, which factor has had the **most** impact on your ability to find home care services for **Medicare** patients? **(Check one)**

1. [40%] **Medicare** program rules and regulations
   (4.1%)
2. [3%] **Medicaid** program rules and regulations (58)
   (1.6%)
3. [10%] Availability of home care services
   (2.8%)
4. [7%] Social or legal situation (e.g.,
   (2.6%) living conditions, family situation, guardianship, conservatorship)
5. [5%] Need for complex and/or skilled services
   (2.1%) (e.g., feeding pumps, IV's, respirator's)
6. [5%] Chronic care problems (e.g., Alzheimer's
   (1.9%) disease, pulmonary disease, incontinence)
7. [9%] Other, please specify

   _____

(8%) Multiple responses

(14%) Did not respond/skip from 10

APPENDIX V

12. For fiscal year 1985, please estimate the percentage of **Medicare** patients, referred to you, who were discharged before plans for post hospital care could be completed. (median)

1% Percentage discharged before plans completed (60-61)

13. How often do you have follow-up contact (outside the hospital) with **Medicare** patients once you have discharged them to post hospital care services? **(Check one)**

1. [17%] Seldom, if ever **(Skip to 15)**
2. [47%] Sometimes
3. [15%] About half the time (62)
4. [13%] Most of the time
5. [7%] Almost always

(2%) Did not respond

14. Which of the following types of follow-up contact were made with **Medicare** patients discharged during 1985? **(Check all that apply)**

1. [17%] Visits to patients outside the hospital (63)
2. [70%] Telephone contacts with patients or family (64)
3. [72%] Contacts with post-hospital providers (65)
4. [12%] Other, please specify (66)

_____

APPENDIX V

15. In your community, to what extent, if at all, have the following national events or trends affected access to post-hospital care services for **Medicare** patients? **(Place an "X" in the appropriate box.)**

	TREND (Makes access) ⟶	Much more difficult since 1982	Somewhat more difficult since 1982	No difference since 1982	Somewhat less difficult since 1982	Much less difficult since 1982	Don't know/no opinion	Did not respond	Average	Sampling error
		1	2	3	4	5	6			
a.	Increasing numbers of **Medicare** patients	23%	39%	20%	4%	1%	8%	(67) (4%)	2.10	.013
b.	Introduction of **Medicare** DRG's or State Hospital Rate Setting Program	51%	28%	8%	3%	2%	5%	(69) (4%)	1.65	.013
c.	Increased use of complex medical equipment in post-hospital care (respirators, feeding pumps, IV's, etc.)	33%	32%	13%	6%	5%	6%	(71) (4%)	2.10	.017
d.	Growth in the number of home health agencies	3%	4%	25%	33%	23%	6%	(73) (6%)	3.79	.014
e.	State control over the construction of new skilled nursing facilities	24%	20%	24%	4%	2%	20%	(75) (5%)	2.21	.017
f.	Changes in the supply of **Medicare** certified skilled nursing home beds	24%	18%	24%	10%	6%	10%	(77) (4%)	2.42	.018
g.	Other, please specify _____	12%	2%	-	-	1%	2%	(79) (83%)		

APPENDIX V

16. In thinking about the quantity of services needed by Medicare patients, do you feel that the current supply of the following "post hospital health care services" serving your community is adequate or inadequate? **(Place an "X" in the appropriate box.)**

Start card 2 (1)

I.D. No. _____ (2-4)

SERVICES	Very inadequate 1	Inadequate 2	Marginal 3	Adequate 4	More than adequate 5	Don't know/no opinion 6	Did not respond	Average	Sampling error
a. Skilled nursing beds	27%	24%	16%	26%	6%	-	(8) (1%)	2.60	.016
b. Rehabilitation centers	15%	20%	16%	38%	4%	4%	(10) (3%)	2.97	.017
c. Home health care	4%	7%	12%	49%	25%	-	(12) (2%)	3.86	.014
d. Adult congregate living facility	24%	26%	20%	17%	3%	7%	(14) (3%)	2.44	.017
e. Intermediate care beds	19%	23%	18%	30%	6%	2%	(16) (2%)	2.	.018
f. Homemaker services	24%	27%	22%	22%	2%	1%	(18) (2%)	2.49	.016
g. Hospices	26%	20%	16%	28%	4%	4%	(20) (3%)	2.61	.018
h. Other, please specify _____	11%	4%	1%	1%	-	-	(22) (83%)		

APPENDIX V

17. Please feel free to provide us any other comments you may have concerning post hospital care services for Medicare patients. [52%]

(24)

RESPONSES BY DISCHARGE PLANNERS TO OPEN-ENDED QUESTION ABOUT MEDICARE AND POSTHOSPITAL CARE

The final item in our questionnaire encouraged the discharge planners to "provide us any other comments you may have concerning posthospital care services for Medicare patients." Instead of conducting a detailed content analysis of these responses, we have categorized them into broad classes intended to illustrate some of the perceived problems surrounding access to posthospital care. In particular, we examined the responses for the purpose of providing some additional sense of what discharge planners might have meant when they chose "Medicare program rules and regulations," "chronic care needs," or one of the other factors as the most important barrier to placing patients in posthospital care (see tables 2 and 4 in the body of the report). A majority of the respondents (54 percent) provided at least some written comments. The responses range from single sentences to more than a page. Discharge planners from all regions of the country responded to this question at about the same rates; fewer discharge planners in rural areas than in urban areas responded.

In summarizing the comments, we begin with those related to patient placement in SNFs, followed by those pertaining to home health services. In both instances, the information reflects only the opinions of the discharge planners who chose to respond to this question. It cannot be considered representative of the respondents to the survey or of the nation as a whole.

COMMENTS RELATED TO PLACEMENTS IN SKILLED NURSING FACILITIES

About 69 percent of the discharge planners providing overall comments wrote about access to SNFs. Of those providing comments about SNFs, about 67 percent raised issues which provide some indication of the concerns that might have been subsumed under the category of Medicare program rules and regulations as they affect SNF placements. For example, almost two-thirds of the respondents' comments about Medicare program rules and regulations (64 percent) convey a perception that the Medicare program has changed the way in which individual eligibility and coverage determinations are made. This perception was expressed in different ways including cuts in coverage, tightening of determinations, changing criteria, restrictive definitions of skilled care, and similar expressions. One respondent suggested that Medicare had adopted "nearly impossible guidelines for qualification."

Respondents commenting about Medicare program rules and regulations did not generally identify specific types of care that should be considered "skilled" but were not. However, some of the discharge planners commented that some patients were very difficult to place in SNFs because their care needs were either too great for the SNF to handle (i.e., "heavy care"; 29 percent) or too costly

given the level of Medicare reimbursement (10 percent). As one discharge planner wrote,

> "The burden of 'sicker patients' also falls on the SNF's who are now being asked to take a much higher percentage of patients who require a much greater intensity of care. They are not, in their opinion, adequately reimbursed for these services; . . . therefore they are 'picking and choosing' among the bountiful (numerous) hospital patients who need SNF care."

Such patients include those on respirators, those with multiple decubitus ulcers, and patients requiring extensive observation. Some (about 30 percent) felt that Medicare should consider reimbursement for a wider range of "institutional services" including intermediate nursing home care, board and care homes, and foster care.

Reimbursement mechanisms for skilled nursing care were also mentioned by the discharge planners commenting about Medicare program rules and regulations (about 27 percent). The thrust of these comments was that Medicare reimbursement alone is rarely sufficient to induce SNFs to take a patient. Usually, the patient must either be eligible for Medicaid or be able (i.e., demonstrate via insurance or other means) to pay for care when the Medicare copayments start. In addition to the access issue, the discharge planners also noted the financial implications of an extended nursing home stay on a patient's ability to return home at a later time. One discharge planner commented that "more and more patients are being forced to liquidate their assets in a 'spend-down' program while awaiting eligibility for Medicaid." Another discharge planner said "Medicare is being viewed as a non-benefit relative to nursing home care."

A number of discharge planners commenting about access to SNFs (about 18 percent), particularly in rural areas, felt that the supply of nursing home beds was inadequate. In rural areas, this comment was almost always associated with the information that beds were available at some distance from their hospital (often 40-90 miles). A few discharge planners felt that state control of supply through the certificate-of-need process had contributed to the overall shortage. As one discharge planner wrote in response to our question,

> "Medicare beds are available to our patients but there are only 30 beds in this area and these are usually full. Therefore the family and friends of the patient must travel 50 to 75 miles to visit. This hardship is difficult to bear along with the sad reality that they must go to a 'Nursing Home.' Several groups have expressed the desire to open another skilled facility because there is a need but are unable to get a Certificate of Need from the state."

A variety of other issues were raised by relatively small numbers of discharge planners. A number of discharge planners (14 percent) suggested that some nursing homes avoid taking Medicare patients even though their beds were Medicare-certified. This behavior is possible because many nursing homes have their choice of several patients for any available bed. Several discharge planners felt that the swing-bed program had helped alleviate some problems and should be expanded.[1]

Information supplied to patients by the Health Care Financing Administration about Medicare posthospital-care benefits was characterized by a number of discharge planners (17 percent) as inaccurate and misleading. Many patients are genuinely surprised when informed that Medicare will not pay for their posthospital convalescence. Guardianship or family responsibility was also raised as an issue by several discharge planners; this is represented in the body of the report as the "social or legal situation" of the patient. To quote one discharge planner, "Many nursing homes require a 'responsible party' other than the patient and often no one is available." In summary, one discharge planner put it this way:

> "Very few patients qualify for skilled level care under Medicare regulations. The few that do qualify are not accepted by ECFs (another term for SNFs) because they require 'too much care,' and 'are costprohibitive.' For example, it is impossible to find ECF placement for respirator patients unless they are private pay at $300.00 daily."

COMMENTS RELATED TO PLACEMENTS IN HOME HEALTH CARE

About 72 percent of the discharge planners providing overall comments wrote about home health care. Many of the comments about SNF placements were also among the issues raised about home health placement. Of those making comments about home health care, 84 percent wrote comments that could be subsumed under the category of Medicare program rules and regulations including eligibility and coverage determinations, as well as the range of services covered by Medicare. For example, several discharge planners (8 percent) noted that the "homebound" and "intermittent care" coverage criteria were particular problems, along with restrictive interpretations of "skilled care."

However, the issue raised by most respondents (62 percent) was the lack of coverage for nonskilled services in the absence of skilled care needs (or the cutoff of those services "prematurely"). The types of nonskilled coverage most often reported as needed

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[1]The swing-bed program allows small, rural hospitals to switch hospital beds to SNF beds (and receive reimbursement at the SNF rate) and back without changing their certification.

include homemakers, chore services, extended observation, as well as "custodial" and "chronic" care. A few discharge planners felt that this type of care would keep patients out of nursing homes and cost less in the long run than long-term nursing home care or repeated hospital readmissions. However, one discharge planner expressed the view that home care

> "is extremely costly and gives inadequate coverage. . . . To provide a Home Care aide to a client for eight hours a day more than exceeds half the daily (twenty-four hours) room rate of a nursing home and the patient is still uncared for, for sixteen hours of the day."

Finally, some of the discharge planners commenting about access to home health care (32 percent) noted problems with the availability of community support services. These services range from meals on wheels and home visitors to adult day care, transportation, and alternate living arrangements (e.g., board and care homes). Even when these services are available, the waiting lists to receive the services may be so long that the patient's need often passes by the time the services are available. As one discharge planner put it,

> "Home care services are available to the elderly through the [...] County Area Agency on Aging. However, there are long waiting lists for services, and it is almost impossible to arrange for service to commence immediately upon discharge, a time when home services such as home delivered meals are crucial. Often, by the time services are given, due to lengthy waiting lists, the patient's need is less urgent. Services which are lacking in [...] County are affordable personal care homes, foster care and respite care/companionship type services."

COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Note: GAO comments supplementing those in the transmittal letter appear at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT 27 1986

Mr. Richard L. Fogel
Director, Human Resources
Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Posthospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow

Richard P. Kusserow
Inspector General

Enclosure

APPENDIX VII

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Post-Hospital Care: Discharge Planners Report
Increasing Difficulty in Placing Medicare Patients"

GAO's report responds to a request from the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. The Chairman requested information about access to post-hospital care for Medicare beneficiaries. GAO summarizes information obtained through a survey of hospital discharge planners regarding their perceptions about problems in placing Medicare patients in post-hospital care and the reasons for those problems.

See comment 1. Given the fact that the report is based on the perceptions of hospital discharge planners as contrasted with quantifiable data, it is extremely difficult to evaluate.

See comment 2. For example, the report states that the most frequently given barrier to placement in post-hospital facilities is Medicare rules and regulations. This statement is undefined and does not identify any specific problem in law, regulation or implementation of policy.

See comment 3. In addition, the report alleges that most discharge planners found it more difficult to place Medicare patients in skilled nursing facilities and home health agencies in 1985 than in 1982 prior to the prospective payment system (PPS). We would note that the discharge planners' views, as summarized by GAO, made no claim that current discharges are being made at medically inappropriate points. Rather, discharge planners' concern seems to stem from the possibility that their jobs have been made more difficult because hospitals, under the incentives of PPS, are acting in a medically more appropriate fashion than in the past.

See comment 4. We would argue further that the issue is not whether the discharge planners' job is easy or difficult, but whether it is being performed adequately so that individuals get the care they require and experience good health outcomes after being discharged. In any event, and whatever the patterns, PPS is only one factor contributing to recent changes in the delivery of post-hospital care.

See comment 5. Finally, we should like to point out that providing the FY 1987 budget allows, HCFA will be conducting a discharge planning conference next year to evaluate various discharge planning practices. In addition, HCFA in conjunction with the Assistant Secretary for Planning and Evaluation is designing a post-hospital discharge survey to gather hard evidence on the services beneficiaries receive after being discharged and the relationship of services received to health outcomes. Also, Peer Review Organizations are looking at the adequacy of discharge planning for possible inclusion in their generic quality screens.

GAO COMMENTS

1. We agree with the Department's observation that our survey presents the perceptions of discharge planners; this is self-evident from the title of our report. We construe the Department's point that data we present are not "quantifiable" to mean that our data, while quantified, are "soft", attitudinal data rather than "hard" data. Again, we have pointed out in our report (see pp. 6-7 and appendix II) that while we would have preferred to obtain "hard data" on access, our pilot tests indicated that the data were either unavailable or would have required excessive time and effort to obtain. As a result, we sought the expertise and judgement of discharge planners because they are the trained professionals who are in the best position to know about problems in placing Medicare patients in posthospital care.

2. HHS states that we do not define "Medicare program rules and regulations" referred to as a barrier to posthospital care or cite any specific problem in law, regulation or implementation of policy. However, we do provide an indication on pages 7-8 as to what discharge planners meant with regard to "Medicare program rules and regulations." These statements are based on an analysis of discharge planners' responses to an open-ended question about posthospital care (see appendix VI) which indicates, for example, that discharge planners were particularly concerned about the trend toward tighter interpretation of the existing Medicare regulations on eligibility and coverage.

3. The Department expressed concern about our treatment of the perception of discharge planners that access was more difficult in 1985 than in 1982. They argue that the apparently greater difficulty in placing patients may reflect increased demands on discharge planners because hospitals were acting in a medically more appropriate manner as a result of PPS. However, this explanation is speculative--HHS has not presented data to suppport it, nor can we address it with data from our survey. What is clear from our data is that discharge planners believe a number of factors have affected access to posthospital care, including PPS.

4. The Department indicates that the issue is not whether the discharge planners' job is easy or difficult but whether individuals get the care they need and experience positive outcomes after hospital discharge. We agree that these outcomes are the proper focus. As noted in our earlier report (PEMD-86-10), however, the data bases necessary to track posthospital outcomes and answer these questions were not established by HHS in a timely fashion. Finally, we would like to point out that we did not ask the discharge planners whether their jobs are more difficult. We asked a nationally representative group of professionals with experience in placing Medicare patients in posthospital settings for their perceptions about access to posthospital care.

5. Finally, the Department mentions several activities for our consideration, none of which appears to address the access issue.

The discharge planning conference and Peer Review Organization activities appear to be concerned with the quality of discharge planning activities and not necessarily with whether or not individual beneficiaries receive the services they need. The survey that is mentioned may develop "quantifiable data" on access but has not been developed to the point where we can comment on its design.

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